



**RELEASE OF INFORMATION
FOR VERIFICATION MEDICAL OR PHYSICAL DISABILITIES**

****Student will complete this page and provide it to their clinician. The clinician will complete the verification form.***

I, _____, hereby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for accommodations.

Student's Signature _____

Phone: _____

Student's Z# _____

Date of Birth: _____

Check the applicable box below to determine how SAS will receive the verification form:

- Please return the completed verification form to client/student.
- Please return the completed verification form to the Student Accessibility Services office:
 - Florida Atlantic University- Boca Campus
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184
 - Florida Atlantic University- Jupiter Campus
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819



**STUDENT ACCESSIBILITY SERVICES
DOCUMENTATION FOR MEDICAL OR PHYSICAL DISABILITY**

This form should be completed **ONLY** by the clinician.

Important: Please note, changing an existing document after it has been signed, faking a signature, or making a false document are all considered to be a forgery.

CLINICIAN NAME (PRINTED): _____
SIGNATURE OF CLINICIAN: _____
CREDENTIALS: _____ SPECIALTY: _____
LICENSE/CERT. #: _____ STATE _____
DATE: _____

My signature verifies that I am or have been this student's treating health care professional and that all the contents below are true and accurate.

Student Name: _____

1. Diagnosis(es): _____

2. Prognosis: Permanent _____ Temporary _____
If temporary, how long? _____

3. Does the disability and/or disabilities limit the student's mobility?

Yes ____ No ____

How so? _____

4. Is the student on any medication that may affect attention, concentration, or any other facet of learning? Yes ____ No ____

Medication(s): _____

Side Effects: _____

5. Describe in detail the student's symptoms/functional limitations associated with their diagnosis(es). How might these impact the student academically?

6. Are there any specific academic accommodations you would recommend for this student? If so, please explain why.

7. Is there any other information you would like to provide regarding this student?
